pillows and her feet in the air, chewing on her tongue.

She does have some days in which she does better, according to Mom, that she's described as that she's fine. But other days she will not listen to what Emily says and will not obey her, or she'll do things that she knows are not right. And Mom gave the example of taking her brother on a scooter ride around the base, which is, you know, obviously dangerous for a young child.

She will take out scissors and cut things with them randomly, sort of impulsively. So they don't let her use the -- use the scissors unless she's calm. They hide markers because she'll -- otherwise, she'll write places she's not supposed to.

Mother reported when I asked her her symptoms -- I gave her also a Vanderbilt -- I asked her the questions on the Vanderbilt, actually, and Mother reported that Estella has -- often has difficulty with -- let's see -- fidgeting or squirming in her seat, acting as if driven by a motor, losing things necessary for tasks or activities, blurting out answers before questions have been completed, and is easily distracted.

She also often has trouble awaiting her turn, talks too much, avoids tasks that require sustained mental effort, has trouble playing quietly, does not following through on instructions, runs about at inappropriate times, does not seem to listen when spoken to directly, leaves her seat when she's not supposed to, and has difficulty sustaining attention in tasks -- or to tasks or play activities.

She also -- Mother also reported that Estella is -- is often loud, she likes to test limits, she'll use words that she's not supposed to use. When angry, she -- she threatened her mother, she threatened to put chemicals in her mother's pillow. She talks back to both parents. And this was confirmed by Father.

She is -- was described as often losing her temper; defying or refusing to go along with her parents' requests; deliberately annoying people; as being touchy or easily annoyed; as bullying or intimidating others; and as lying to get out of trouble or avoid obligations.

She also was described by Silas as being, in his words, "borderline obsessive compulsive." He gave some examples of the behaviors that he felt

sentences and was intelligible. She was cooperative. She wasn't shy. Her mood was bright and her affect was -- was congruent.

She didn't, you know, express any sort of bizarre kinds of thoughts or -- or anything like that. We played together briefly, and her play themes were all what would be considered normal for a child her age. And she interacted appropriately with her baby sisters.

She put away her toys after using them. And I did observe her mother ask her to do a couple of things. And on those occasions when I was watching, she, in fact, did do what she was told.

Q. Okay. So Dr. Elwyn, based on your -- and thank you -- your extensive review of the records, your exam, the interviews that you've done with the parents and the -- the teachers, and your observations of the child, do you have an opinion, to a reasonable degree of medical certainty, as to whether Estella has any psychiatric disorders?

A. Yes, I do.

Q. And what is that opinion?

A. Well, my opinion is that she does have some psychiatric disorders. And I will use the DSM-IV classification to outline those.

In psychiatry, of course, we talk about Axis I diagnoses being sort of the primary focus of concern and then, you know, Axis II sometimes being a focus if -- if there's a personality disorder or mental retardation. But primarily we look at Axis I as indicating the psychiatric pathology.

Based upon my review, I believe that she has Attention-Deficit/Hyperactivity Disorder, Predominantly Hyperactive-Impulsive Type. And I also believe that she has Oppositional Defiant Disorder. And finally, she has a history of an Anxiety Disorder, but I don't -- but I would label that as "Prior History" because I don't think at this point in time it's of -- an issue of clinical concern.

So the bases for my opinion that she has ADHD are based upon, as I said, my review of the -- of the records, the -- you know, the -- the narrative conveyed by both the parents, and also the evidence from numerous observations from different parties that -- regarding her behavior, so that it's not just only based on what the parents have said but also things like the Conners' Rating Scale by the preschool teacher and the various behaviors observed by various parties.

So if we look at the diagnosis of ADHD and what's required for it, if we're looking at the hyperactive-impulsive type, then we look at having six or more symptoms that are of the hyperactivity-impulsivity spectrum.

And these are things like, you know, fidgeting with hands or feet or squirming in seat, leaving seat in classroom or in other situations in which seating -- or remaining seated is -- is expected, running or climbing about excessively where it's inappropriate, having difficulty playing or engaging in leisure activities quietly, being on the go, talking incessively, you know, blurting out answers, having difficulty waiting her turn, or interrupting or intruding on others.

So I -- I believe that the review of the records and -- and -- and the information conveyed to me by the family suggests that she has had the -- she has met criteria for this type of ADHD.

And there are some other criteria as well, and she's also met those. Those being that the symptoms were present before age seven years, which is -- is, of course, the case; and that there has been impairment from the systems in two or more settings, such as at school or work and at home; and

that there is evidence of clinically significant impairment in social, academic, or occupational functioning; and that the symptoms do not occur exclusively during the course of a pervasive developmental disorder, schizophrenia, or other psychotic disorder, and are not accounted for by another mental disorder.

Okay. So we know that parents have described her as -- by the age of 20 months as being very energetic. When she was in preschool, she had difficulty sitting in a group during structured time, she ran around in circles. She was described as impulsive and distractive. And it's also noted that this behavior appeared to interfere with her learning at -- even at that early age.

The -- the report by Dr. Urion, again, notes that she has several -- several behavioral issues related to impulsivity, inattention, and hyperactivity that are also seen in children with this history of neurological injury.

Dr. Marumoto, again, described the behaviors that she saw, things like constantly fidgeting, swaying side to side, touching lips with fingers, touching her hair, being easily distracted during the group, and was noted to have ADHD

features of distractibility and impulsivity that may be treated.

And then finally, Dr. Robert Pedersen, the pediatric neurologist at Tripler, also observed ADHD symptoms with impulsivity, inattentiveness, and some hyperactivity.

Okay. So those, along with the information supplied by Mrs. -- Ms. Kim, the preschool teacher, are suggestive that certainly at that period of time she had these symptoms, and they were impacting her functioning at school.

And so in my original report, I indicated that -- there's also some information from -- from the school regarding her behaviors and why she was made eligibility for special education. So -- so based upon those factors, I felt it was clear that she met criteria.

When I spoke with her -- with her kindergarten teacher, Ms. Greenamyer, Ms. Greenamyer indicated that she wasn't having much in terms of impairment at school. And so I added the qualifying statement that her ADHD was "In Partial Remission" to my diagnosis.

Q. Now, that -- that was back in the spring of '06. But I take it you now feel -- your opinion is

now that it is not in partial remission and that she does meet all the criteria for Attention-Deficit/Hyperactivity Disorder; correct?

A. Yes, that's correct. You know, the new evidence suggests that it's likely that it's -- it's no longer in partial remission and that that qualifier -- that that qualifier no longer applies.

I ordinarily would like to speak with the teacher myself to get a little more thorough understanding. But -- but based upon what I have before me, I would say that it's -- it's fair to say that her ADHD has not abated and that it -- it continues, and continues to be a problem.

Q. Now, do you have an opinion, to a reasonable degree of medical certainty, as to whether Estella's injuries, her injuries to her brain in neonatal period -- and in particular, the intraventricular hemorrhage, the seizures, the thalamic hemorrhagic infarction, the dural vein thrombosis -- do you have an opinion to a reasonable degree of medical certainty as to whether these neonatal injuries were a substantial contributing factor in causing her Attention-Deficit/Hyperactivity Disorder?

MR. GIEDT: Objection, for the record.

Motion to strike. In accordance with Rule 26(a)2(B), the expert report prepared and signed by the witness shall -- shall include a statement of all opinions to be expressed and the basis of reasons therefore, the data or other information considered by the witness in forming their opinions.

And while you've done that for ADHD, the report that you've turned over really has no basis or opinion for any -- no basis or conclusion of what you considered for determining what your opinion about the relationship and causal relationship between the cerebral issues were.

Q. BY MR. APPEL: You may -- you may continue.

A. Okay. If I recollect your question, it was do I have an opinion regarding causation of her ADHD.

Q. Yes.

A. Yes. And, yes, I do have an opinion.

Q. And what is that?

A. My opinion is that the injury that she suffered, the neurological or brain injury that she suffered after birth, is an important contributing factor to the development of her ADHD.

Q. And could -- could you just briefly give

the basis for that.

A. Yes.

MR. GIEDT: Objection. And motion to strike. It's nowhere in the report.

MR. APPEL: We --

THE WITNESS: Sure. Yes.

The basis for that is -- there are a couple of bases for that.

The first basis for that is that, you know, it's clear that -- that everyone who has evaluated this child has expressed concern that, you know, this -- that -- that ADH- -- well, not everyone has expressed -- let me start again -- that at least Dr. Urion, the behavioral neurologist had, you know, stated that this is the kind of -- you know, ADHD symptoms are the kinds of things that you would see in a child who suffers this kind of -- this kind of brain injury, would be one basis.

A little more specifically, although I'm not -- you know, I'm not a researcher, I'm a clinician. Still, I've reviewed the literature to some extent. And my understanding is that children who experience intraventricular hemorrhage are at increased risk for ADHD. I think there's -- there's literature out there that supports that.

And -- and finally, you know, causation with regard to ADHD is -- is kind of difficult because we can't say with certainty what causes ADHD. So to say something -- you know, for me to -- to say with any, you know, definiteness, I guess, would -- would not be true. But based upon our current conceptualization of ADHD, I'd say it's more likely than not that -- that this was important.

And -- and the final part would be that the -- that the -- the stroke or the -- you know, the infarction to the right thalamus also would place her at more risk for developing ADHD just because the -- the thalamus is -- is involved intimately in sort of the neurocircuitry that sustains attention and suppresses competing -- you know, competing -- things that compete for our attention, and a stroke in that area could be quite significant.

And so I think for all of those reasons that it's more likely than not that it's an important contributing factor to the development of ADHD.

Q. BY MR. APPEL: In terms of the other etiological factors -- and I know you've already gone through those things, like family history and

whether there's any genetic predisposition -- did you find anything in the -- those potential etiologies to be contributing here in any significant way?

A. Right. So our current conceptualization of ADHD is that it is a highly -- it's a disorder that's very much genetically linked, or it has a high heritability index; it is very common for parents to have -- who have ADHD, for -- for those children to have ADHD and for -- for children who have ADHD to have parents who have had ADHD. And we know that that's -- that accounts for a substantial percentage of the variance.

In my review, I was not able to come up with any genetic influences that would -- were playing a role here. There was no family history on either side that suggested there was -- that ADHD was present for either parent.

And so when you -- when you don't have something like that, then you look to other sort of biological causes that are specific to the individual -- the individual person to find what might be, you know, sort of causative of the condition.

And so, yeah -- so those things are things

like, you know, use of drugs or alcohol by the mother during the pregnancy, tobacco smoking during the pregnancy, various problems with the birth, things of that nature. And those were all absent. In fact, there was no other sort of biologically based contributing factor that I could find outside of this rather significant brain -- brain injury.

VIDEO OPERATOR: Excuse me. Counsel?

MR. APPEL: Yes.

VIDEO OPERATOR: We have about five minutes left on this tape.

MR. APPEL: Okay. Do you have another tape?

VIDEO OPERATOR: Yeah. Sure do. Do you want to change it now?

MR. APPEL: Okay.

Yeah. Why don't we change it now.

VIDEO OPERATOR: Okay.

We are off record at 2:19.

This marks the end of videotape number one.

(Break taken in proceedings.)

VIDEO OPERATOR: This marks the beginning of videotape number two of the deposition of Todd Elwyn, M.D., held at 980 Ninth Street in Sacramento, California, on March 31st, 2007, in the